Proj. No 489 0708

489 0708 (2)
PD-AAD-480-B1

AID 1025-1 (7-71) (FACE SHEET)

NONCAPITAL PROJECT PAPER (PROP)

I. PROJECT IDENTIFICATION

1. PROJECT TITLE: Health Planning 489-11-590-708

APPENDIX ATTACHED: ☒ YES ☐ NO — 56p

2. PROJECT NO. (M.O. 1095.2)

3. RECIPIENT (specify)
☒ COUNTRY: Korea
☐ REGIONAL ____ ☐ INTERREGIONAL ____

4. LIFE OF PROJECT
BEGINS FY 74
ENDS FY 76

5. SUBMISSION
☒ ORIGINAL 5/29/74 DATE
☐ REV. NO. ____ DATE
CONTR./PASA NO. ____

II. FUNDING ($000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL $	C. PERSONNEL (1) $	C. PERSONNEL (2) MM	D. PARTICIPANTS (1) $	D. PARTICIPANTS (2) MM	E. COMMODITIES $	F. OTHER COSTS $	G. PASA/CONTR. (1) $	G. PASA/CONTR. (2) MM	H. LOCAL EXCHANGE CURRENCY RATE $ US ____ (U.S. OWNED) (1) U.S. GRANT LOAN	H. (2) COOP COUNTRY (A) JOINT	H. (2) COOP COUNTRY (B) BUDGET
1. PRIOR THRU ACTUAL FY												
2. OPRN FY												
3. BUDGET FY 74	500			30		20	150	300	81			241
4. BUDGET +1 FY	210			30			50	130	27			251
5. BUDGET +2 FY												
6. BUDGET +3 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL	710			60		20	200	430	108			492

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT

III. ORIGINATING OFFICE CLEARANCE

1. DRAFTER: John S. Arden/James Dalton/A. David	TITLE: Acting Director, ASIA/TECH	DATE: 5/29/74
2. CLEARANCE OFFICER: James J. Dalton JJD	TITLE: Chief, ASIA/TECH/SPP	DATE: 6/11/74

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

2. CLEARANCES

BUR/OFF.	SIGNATURE	DATE	BUR/OFF	SIGNATURE	DATE
ASIA/EA	B. Richardson	5/29/74	PPC/DPR	R. M. Ward	6/11/74
ASIA/DP	F. Correl	6/11/74	PPC/RC	E. Griffel	6/11/74
TA/H	L. Howard	5/29/74	ASIA/EA	L. P. Oechsli	6/11/74

3. APPROVAL AAs OR OFFICE DIRECTORS
SIGNATURE
DATE 6/4/74
TITLE Acting Asst. Administrator, Bureau for Asia

4. APPROVAL A/AID (See M.O. 1025.1 VI C)
SIGNATURE
DATE
TITLE ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

PROP Contents

I. A. The Sector Goal

Korea's Third Five-Year Economic Development Plan (TFYP) calls for rural economic development accompanied by enhanced public welfare through expanded health, sanitation, and social security programs and facilities. In order to meet this goal and depending on resource availabilities, initiatives in preventive and curative health strategies, institutional and systems design, and tests of constraints as well as potentials will be developed.

B. Measurements of Goal Achievement

These initiatives can be examined, in terms of content and progress achieved, through observation of a number of policy, services, systems, and institutional referrents. Among these, marked changes in the distribution of urban/rural medical facilities and programs and trained medical and paramedical workers in order to reduce inequitable distribution of preventive and curative health services has priority. The services provided are to be low in cost, effective, and strongly contributory to increased economic productivity as well as reduced population growth.

C. Assumptions of Goal Achievement

Korean policy-makers will recognize and accept that there is a causal relationship between changes in policy, increased allocation of resources, programming variables such as different kinds of services systems or the mobilization of the private sector, and goal attainment.

II. A. Project Purpose

Establish a health sector planning capability that will enable government to formulate health strategies and systems through systematic

analysis, assessment of alternative courses of action, and designing sector policy and program inputs to meet specified national health objectives.

B. Indicators of Conditions Expected at Completion of Project

1. An established, staffed, and inter-linked institutional framework in which all the processes of planning and their dependent variables including research, resource allocation, and empirical testing are functioning and affecting health sector policy.

2. An applied set of criteria delineating clearly desired "health status" and "quality of health services."

3. Health sector planning processes, systems, and skills oriented towards:

a. "Objective-directed planning" rather than "budget-directed planning."

b. Data collection, analysis, and operationalization of health sector findings through internal (government) and external (private, university, research institutes) networks designed to continuously affect policy-planning and action.

c. Design, test, and analysis of operations research activities in carefully defined, fully supported, field test conditions.

d. Optimization of effective low-cost preventive and curative services for the rural populace.

4. A functioning, inter-linked, public, semi-public, and private research network addressed to study of the present health delivery system; financing; cost models; manpower resources; utilization patterns;

quality parameters; public sector/private sector; managerial and administrative structure; distribution pattern for services; general behaviorial patterns of population towards existing or test systems, etc.

5. Mid-term in the development of a trained cadre of well-qualified personnel to meet the manpower requirements of the planning, data-gathering, analysis, design, operations research, and research needs collaborating public and private agencies concerned with health sector planning activities.

C. Basic Assumptions Relative to the Project Purpose

1. That the current and next Five Year Plans will indeed give greater emphasis and allocate larger resources to social development.

2. That policy-makers will be willing to accept and test new institutional configurations and responsibilities for the implementation of health sector planning processes and systems.

3. That new health sector planning processes, systems, and institutional configurations can, indeed, be designed that will be appropriate to Korean policy, administrative, and operational optimum needs.

4. That the ROKG will insure the utilization of planning output by strengthening the implementational capabilities of both public and private sector health delivery systems and securing fuller coordination between government agencies concerned with health related issues and the private sector.

5. That technical assistance can, in fact, contribute to:

a. Helping identify appropriate organizational and functional configurations and processes for effective health sector planning.

b. Helping the ROKG identify and catalyze the systems and expertise supportive of effective collaboration in health planning and research both within the public sector and with the private sector.

c. Helping in on-the-job training in appropriate research methodologies, research management, systems design, data-gathering, and analysis related to effective health sector planning.

6. That appropriate ROK professional manpower are trainable and will be available for training in the needed subject matter at appropriate institutions and for the required intervals.

7. That trained Korean professionals will be earmarked for specific assignments, and fully assigned, for specific tasks relevant to the development of effective health sector planning.

8. That the suggested approach, or some close variant thereof, and the phased plan of action outlined in Section VI, Course of Action, of this PROP will be implemented within the time frame of the project.

III. A. Project Outputs

1. A set of health sector policies generated by planning systems and accompanying research which are constantly reexamining and testing the premises underlying health programs and the conditions to which they are addressed.

2. A set of analytical skills and systems, suitably located within the policy-making structure of the government, which insures correct use of data and findings in health sector planning.

3. A number of health planners, analysts, information specialists, designers, and research specialists trained in the skills deemed essential for effective health sector planning.

4. Design and implementation of projects which will test, among other things, the cost-effectiveness of various low-cost health delivery systems.

5. A functioning information system designed to monitor changes in the health sector.

B. Basic Assumptions Relative to Outputs

1. A workable organizational configuration of functions and assignments, related to all of the processes of planning, can be established and staffed appropriately by the Korean government internally and/or in collaboration with the private sector.

2. That the product of field operations research will yield results that can and are translated into policy and program operations.

3. That the products of research done either by government, semi-public, or private entities will be addressed to problems of immediate or near-future concern to health sector analysts and planners.

4. Improving the health sector planning processes and systems will provide appropriate on-the-job training opportunities which are cost-effective and significant in scale.

5. That contracting to meet health sector planning needs will become an accepted, organized, and efficient system of operation within the private and public sectors of Korea.

IV. A. Project Inputs

1. Table 1 summarizes the personnel inputs and their timing while Table 2 summarizes the financial resource requirements needed for personnel, travel, training, equipment, supplies, and contract research funds. The main features of the personnel inputs include:

a. Foreign technical assistance, full-time, for two specialists serving two years. They are to be qualified in providing advice on the organization, processes, and systems of health planning as well as the design/management of operations research tests for systems of health delivery.

b. Short-term foreign technical assistance for up to thirty man-months annually determined by the specifics of the planning/research agenda developed during the first three months of the project and at the end of the first twelve months of the project.

c. Twelve man-years of participant training for the duration of the project.

d. Eight full-time Korean government professional personnel, and supporting clerical staff, capable of defining, organizing, operating, and managing systems of health sector planning including data-gathering, analysis, operations research, and policy-formulation.

2. The main financial resource components include:

a. For USAID:

- Employment and assignment of a full-time, direct-hire, highly qualified health systems planning/management specialist at USAID/Seoul.

- Contract cost of personnel including consultant costs; travel costs; small equipment costs; a portion of the local currency research contract "trust" fund, and participant training costs.

b. For ROKG:

- Direct personnel costs as identified in (1-d) above; direct support costs of the project; a portion of the local currency research contract "trust" fund; and funds to support changes in organization or operation made necessary during the course of project implementation.

B. Assumptions Relative to Inputs

1. That AID can obtain the needed direct-hire and contract personnel to supervise and/or perform the direct advisory services consistent with the job description of Appendix B.

2. That AID and the ROKG will obtain the necessary financial commitments as per Table 2.

3. That the ROKG, with the assistance of AID, can properly identify essential processes of planning and the back-up systems required and then situate the responsibility for their development in the most effective administrative/management environments.

4. That AID will develop a working contract with a reputable and competent research organization capable of servicing the needs of the project.

5. That the first three-month interval for developing the project and the subsequent 12-month review will produce results that will be effectively responded to by the programming and delivery of inputs on the part of both the ROKG and AID.

6. That, in any case, the ROKG will produce the best personnel available to staff the health planning processes and systems; and to make available, at the agreed upon training schedule, the professionals to be sent for training.

7. That AID inputs in support of operational research activities will be flexible, adequate, and appropriate; and that the same will be true for ROKG inputs in this area.

V. Rationale

The Republic of Korea has adopted the planned approach to development. The successful implementation of two plans and the current advances in the implementation of the Third Five Year Plan are but a demonstration of the Korean's capacity to evolve a planning process that permeates the multi-faceted aspects of development. Discussion and thought have been started with regard to the general direction of the forthcoming Fourth Five Year Plan.

Concern with development during the first three plans were mainly directed towards the building of a viable and growing economy. No wonder then that growth rates in Gross National Product and per capita GNP predominated the plans' objectives. Hence, emphasis was rightly placed on the determinants of GNP while significant attempts have been made in containing the rate of population growth in order to safeguard the desired changes in per capita GNP.

Capital generating, and especially export generating activities, have been receiving high priorities. Social development, on the other hand, though recognized as necessary, received less attention in the past. Now the Koreans' desire to bring human "well being" into sharper focus and give greater considerations to certain aspects of human development, especially the provision of a healthy environment.

Investments in health sector have been minimal.[1/] Many reasons may be given for such relatively low priority to such a sector. Only one will be used to highlight some of the inherent problems in planning for the health sector, that is the economics of health.

To a planner, resources are allocated on the basis of their contribution to the attainment of specified objectives. The objectives that are most readily fundable are in most instances readily quantifiable. Hence justification for investments in the health sector must be developed in such a way as to demonstrate "visible" returns. The health planners have been arguing for improved health services in order to produce a healthy labour force which enter more "efficiently" into the productive processes of the economy. But how much efficiency is gained and at what cost is the essential economist retort - particularly when considering these issues in the context of a surplus manpower in the labour force.

[1/] The proportionate share of the Central ROKG budget for health has remained at about the one percent level in spite of the fact that the overall budget as a percent of GNP has steadily increased from 10.8 percent in 1964 to 18.2 percent in 1972. (See ROKG/MHSA Long Term Health Planning, p.7.

Unarmed with "meaningful" economic cost benefit ratios but heavily loaded with humanitarian arguments, health programme administrators, worldwide, tend to revert to identification of their health sector outputs in terms of their own sectoral inputs, such as physicians per 1000 population, hospital beds per 1000 population, etc. -- all of which are inputs into a health sector that must provide "improved health". But what is improved health?

Few will dispute the very wide and widening gap in Korea between the "high quality of health that is afforded by the small 10 percent of the total population and the poor quality of health received by the remaining 90 percent." Is "improved health" then the provision of the "high quality" that the minority is now receiving or is it somewhere in between? If it is in between then where is that level? Can it be defined and if so what criteria are to be used and what mechanism(s) must be effected to arrive at and implement such levels? Or is it really so illusive a concept that what health planners may be forced into becoming engaged in is what one Korean health administrator called "catching a cloud"?

This PROP has as its starting point the belief that the process of defining the health sector's objectives and the criteria against which appropriations and subsequent evaluation of success or failure is feasible, meaningful, implementable but difficult and long-term in nature.

The current state of affairs in ROKG health planning has followed the annual budgetary and project planning approach. Within MHSA each bureau prepares its annual "plans" on the basis of an expansionary goal aimed at reducing the incidence of certain communicable diseases or extending the delivery of curative services.[2/] Health Centers established in the 192 counties emphasize preventive medicine and communicable disease control while 12 provincial hospitals provide the curative treatment, though "very weak in quantity and quality." Detailed statistical indices

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2/ At present the MHSA has 1 Office of Labor Affairs, 1 Coordinating and Planning Office, 7 Bureaus and 34 Sections.

of health infrastructure and state of health as reflected in morbidity and mortality statistics are appended as Appendix C.[3/]

Budgetary allocation for health through the MHSA remained at about the same level during 1971 and 1972 (10.14 bil. Won in 1971 vs. 10.16 bil. Won in 1972. See Table 1, Appendix C.) External sources of funding various health related activities have not been significant. Total estimated foreign assistance to ROKG/Health Sector amounted to over 27 million U.S. dollars.[4/] (See Table 2 Appendix C) How efficient have the use of such resources been and what were the benefits? Although the benefit issue is not detailed here, but reference to changes in mortality and morbidity indices are included in Appendix C Tables 3 and 4, it, nevertheless, merits a brief discussion at this point.

Efficiency is a mathematical relation between inputs and outputs. The health sector's inputs

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3/ For further supporting evidence of the State of the Art of the health system in the ROK see Health Sector Survey Team Report, Preliminary Reconnaissance - Sector Report-Health Sector, Korea, AID/W, November 1973, and the Briefing Document on South Korea - The Health Sector, AID/W.

4/ USAID/K estimates total direct USAID contribution to health related activities amounted to over 20 million dollars between 1965-1972 and 12 million of this amount was in family planning.

include physical facilities such as hospitals, health centers, health sub-centers and their accompanied equipment and supplies. In addition manpower inputs into the various health delivery units should be considered along with the "manpower generating" units such as medical, nursing and paramedical technical schools.[5/]

One would ideally wish to aggregate the total physical and manpower inputs and relate them to some output criteria. However, this may rather be impossible to do at this juncture but some proxy indicators of efficiency values may serve the purpose. For example, improvement of hospital bed utilization rates, increased number of T.B. vaccinations per paramedical, etc. What can be readily concluded after a close scrutiny of both the physical as well as the manpower input deployment and utilization is that they have been utilized at relatively low efficiency levels.[6/]

5/ The medical and paramedical training institutions are producing the graduates and diplomats but at what efficiency levels is beyond the scope of this particular PROP though not beyond the domain of activities of Health Sector Planning analysis.

6/ There seems to be enough conviction among health practitioners that even though physicians may be available to rural and slum areas, the number of patients seen per physician per day is "very small." The number of pharmacists sought for quick medical treatments seems to be "in greater demand." (Personal observations of TDY/W Health Sector Team 1 and 2 and discussions with medical educators in medical schools in Seoul).

Mobilization of professional talents to deal with the national social policy issues as they relate to the health sector must be addressed to the following illustrative substantive and organizational issues:

- If the rural-to-urban gap in medical services were to be narrowed, should not Government be concerned with the estimation of effective demand for rural health services and if so how and by whom?

- Assuming an effective demand for rural health services is significant, how best can such services be provided, i.e., what mix of services?

- Assuming an optimal mix of services that will meet this demand is developed, what "optimal" input mix, subject to financial constraints, can be feasibly mobilized?[7/]

7/ Feasible mobilization of inputs, especially manpower inputs, may require changes in the functional responsibilities of various manpower mix and the accompanied changes in the existing laws and regulations to permit such reallocation of functions consistent with needs and personnel availability plus training.

- Assuming an "optimal" input mix is delineated how should such mix be deployed (i.e., phasing by geographic areas)?

- Costing of the "optimal mix" may require additional health budgetary inputs, where will such financing come from, i.e., how much publicly financed and through what mechanisms?

- Will the private sector therapeutic medical services assume a greater role in the expansionary efforts of the health sector and if so what is to be done to curb the rising costs of services?

- What changes in the planning process and organizational structure are needed to effectively address the host of major and axiomatic issues that confront the health sector?

Based on the explorations and inventory taking of the planning processes and organizations, the

following approach and organizational arrangements will be pursued during the life of this project:

- The planning process must be objective-oriented. This means that the proper definition of health sector objectives must be reoriented from input objectives, such as hospital beds-to-population ratios or physicians-to-population ratios to definition of acceptable "health status." Once the objective is defined, then the planning process will move backward as represented in Figure A.

- Three major components of the health planning system must be operationalized. These have been identified in Figure B, as: objective setting; decision-making frames that must be developed to assess movement towards the objective(s)' attainment; and information systems needed to service the decision-making frame component.

Figure A: SEQUENTIAL PROCESS IN PLANNING FOR HEALTH SECTOR

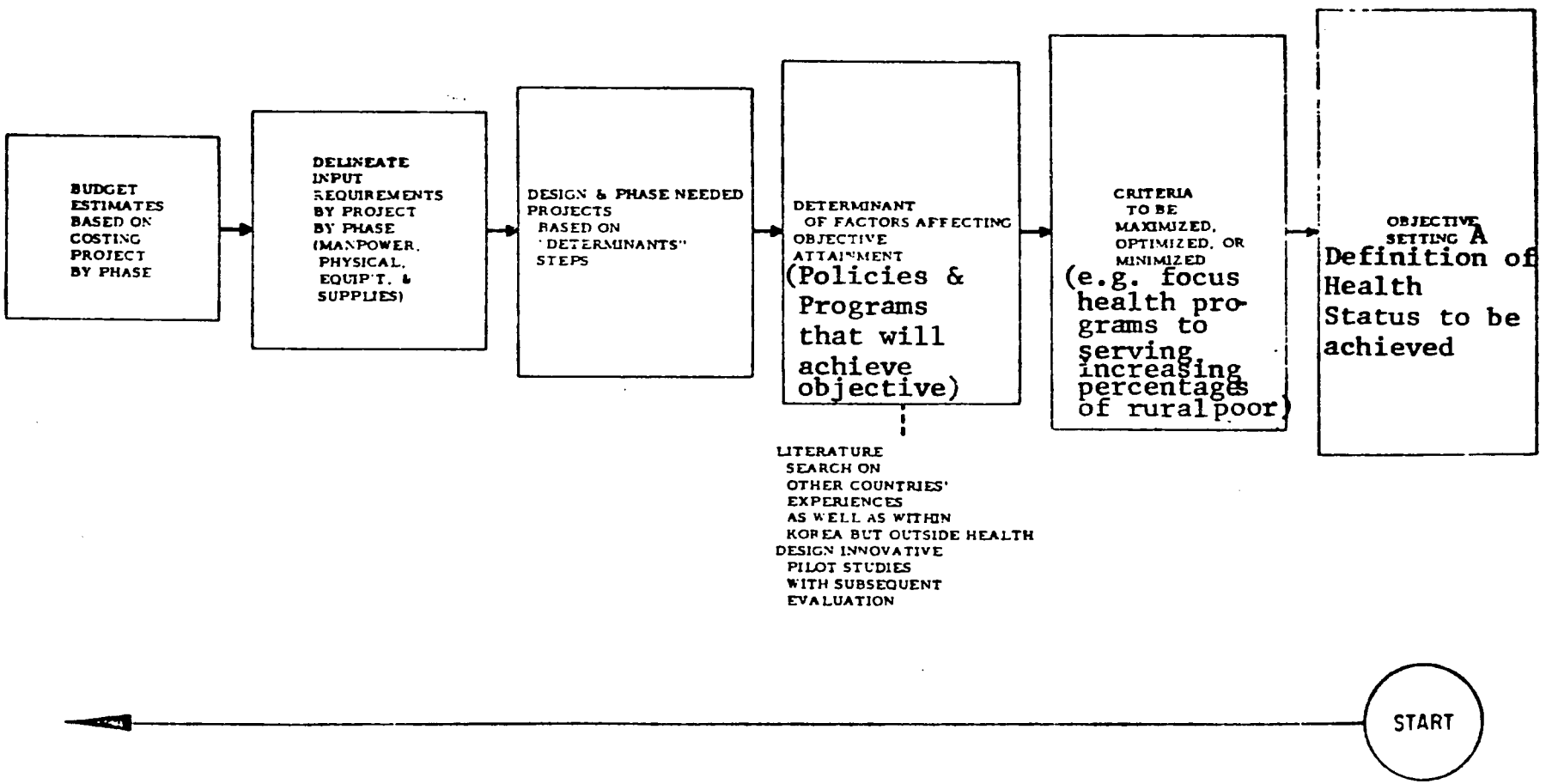
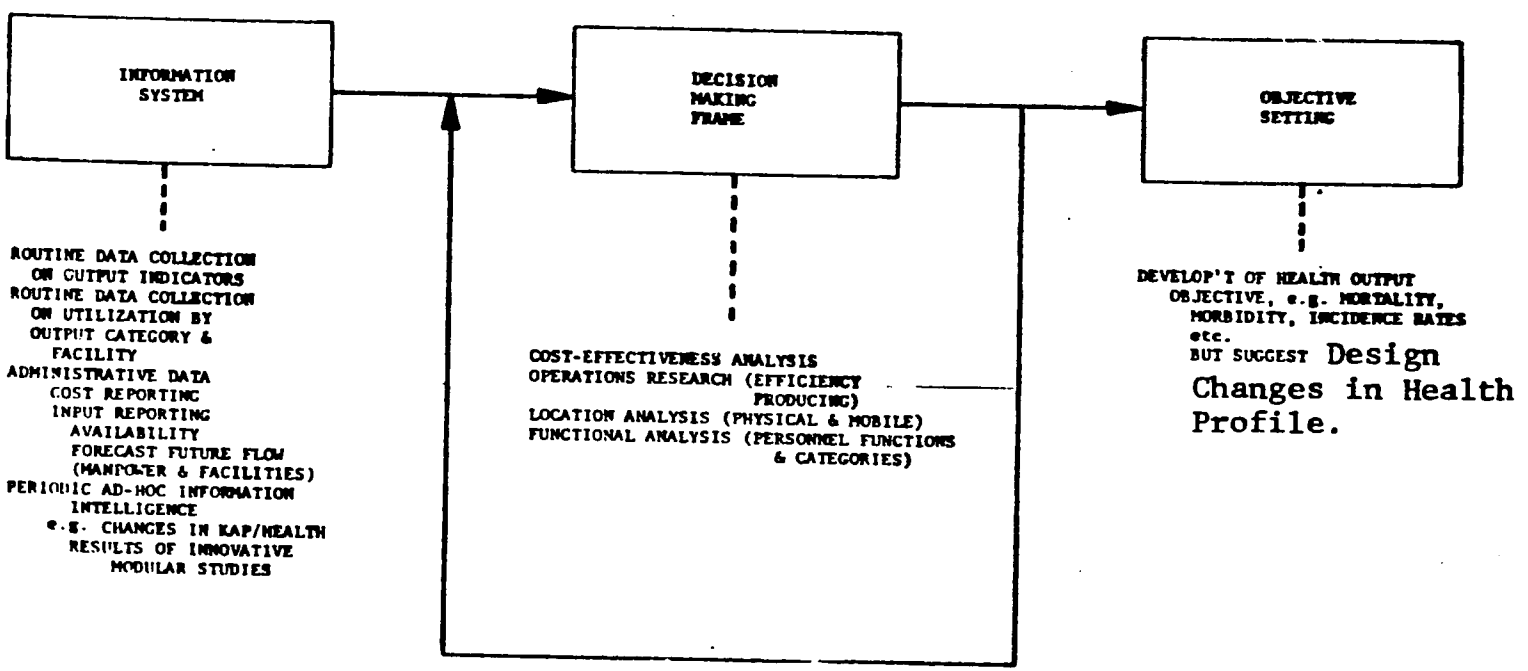


Figure B: HEALTH PLANNING FUNCTIONAL SYSTEMS COMPONENT

BASIC ASSUMPTIONS

1. PLANNING IS CONTINUOUS, DYNAMIC AND RECURSIVE PROCESS.
2. TECHNOLOGY FOR PLANNING IF NOT CURRENTLY AVAILABLE CAN BE OBTAINED, BORROWED & MODIFIED, THEN APPLIED.
3. PLANNING INPUTS AVAILABLE BUT NOT IN PLACE, HENCE WHEN REORGANIZED AND "LUBRICATED", ORGANIZATIONAL MECHANISMS WILL BE DEVELOPED TO MAXIMIZE PROBABILITY OF IMPLEMENTATION.
4. Human and Financial Resources for Planning are not Constraining but for Plan Implementation May Become Constraining, hence Feasible Plan Particulars Become very Constraining Factor in Future Plan Developments.



- The planning process should encompass both improved planning at the provincial, Gun and Myon levels as well as guidance in the implementation processes, i.e., set the stage for and maintain coordinative relationships rather than direct management control. This process is illustrated in Figure C.

- The planning and implementation processes are indeed complex and hence should not be centralized within one organization but rather collaborative working relations must be developed with public and private agencies and institutions.

- Adopt and implement a research management approach such as the one illustrated in Figure E in order to effectively implement the processes of Figure A above.

Figure E: RESEARCH PROCESS PATH / HEALTH PLANNING SECTOR

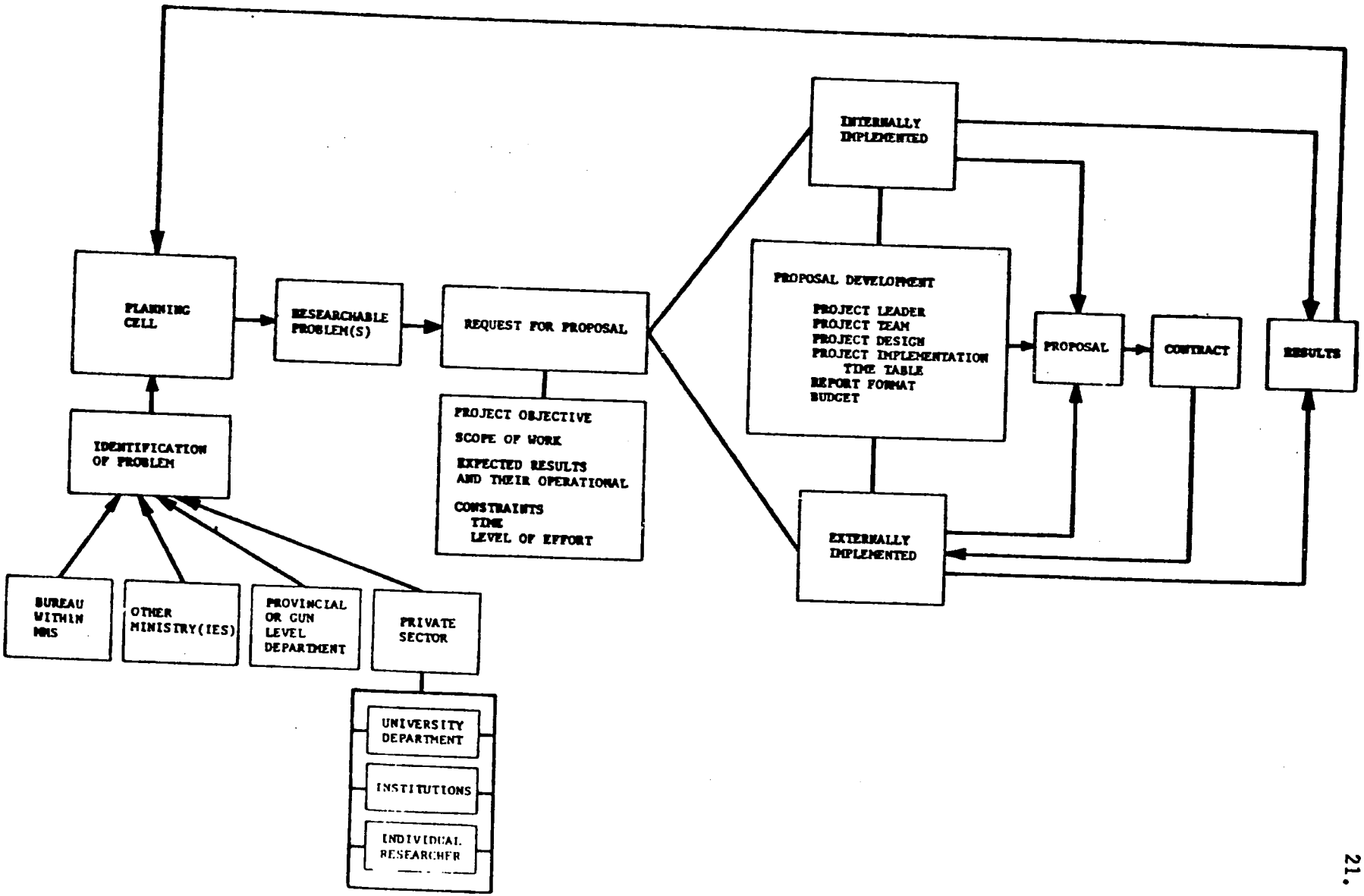
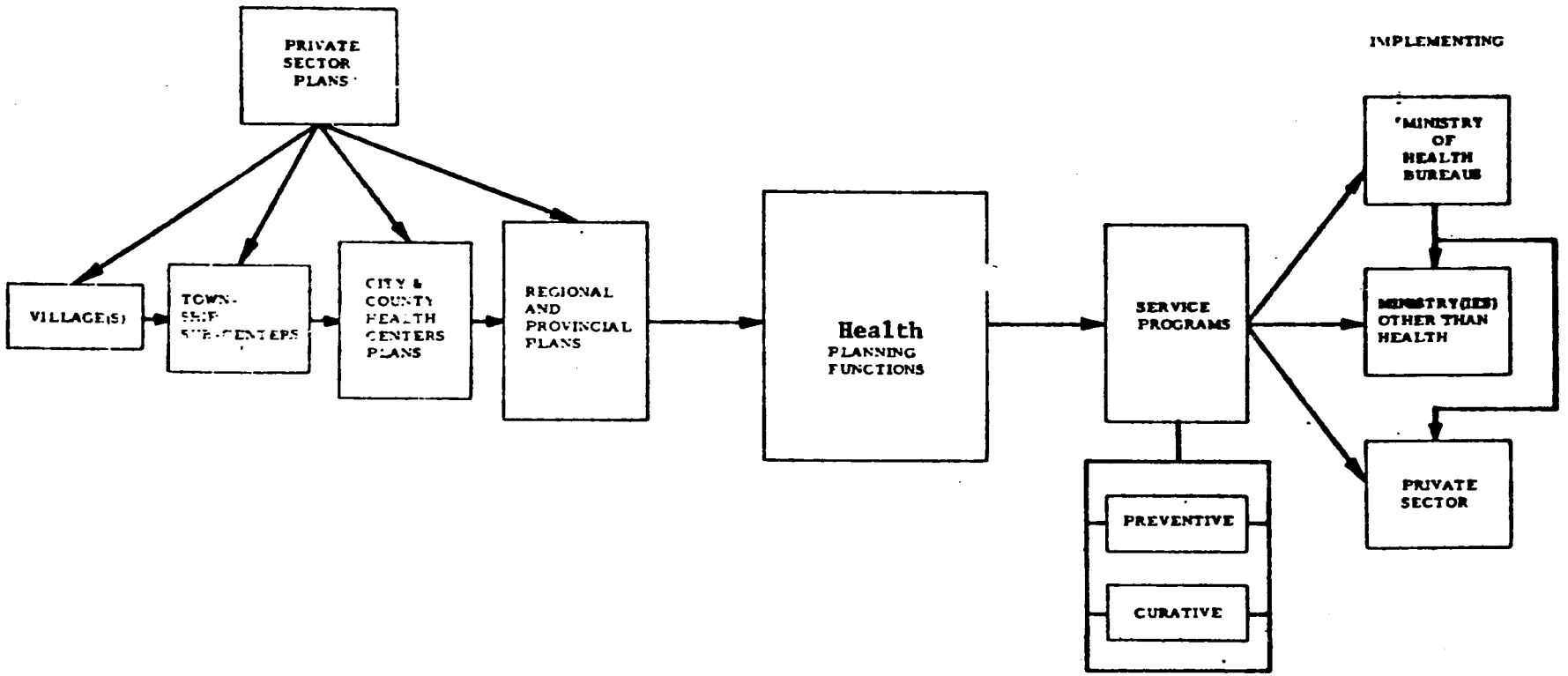


Figure C: ~~HEALTH PLANNING CELL~~ - PLANNING PROCESS FLOW



VI. Course of Action

A. Plan of Implementation

The Health Sector Planning Project is designed to cover a period of two years during which time the ROKG's health planning capability will be enhanced to the point where some specific plans of action for the future delivery system and its financing (e.g., health insurance schemes, etc.) will have been designed and undergoing some degree of test. The two-year interval shall start on or about July 1, 1974, to cover FY 1975 and 1976.

USAID will recruit and staff, by that date, a competent direct-hire employee who will be capable of managing, supervising, and monitoring AID inputs while, at the same time, maintaining a very high degree of communication with Korean planning, health, research, and information specialists both in the public and private sectors.

Under a contract, the project will provide two long-term advisors - one an economist with specific orientation to social services analysis and planning,[8/] and the second a health administration/planner specialist in health delivery systems and their structural-organizational aspects. Short-term consultants will be provided to deal with specific aspects of the total effort such as information systems analysts, health insurance

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8/ The emphasis here is for a practical economist who has applied his skills to health or social services sectors and not a health administration specialist who has some competency with economic analysis. This distinction is crucial because of the simple fact that if health plans and objectives are to carry weight with the economic planners, then he must be professionally accepted by the Korean sophisticated class of economic planners/analysts.

planners, research design specialists, health training specialists, public administrative systems analysts, etc. These consultants will be drawn from the same institution or elsewhere on a work order contractual basis.

The specific activities to be undertaken during the time frame of this project will be worked out during the first three months of the project as well as at the time of a joint ROKG/AID review held at the end of the first twelve months.

Those activities will be mapped with reference to five major phases which must characterize the operation of the project. These major phases (which may overlap or may be started concurrently or singly) include:

1. Organizational Planning

This involves the development of functional statements, the staff qualifications, and organizational configurations as well as linkages deemed essential to definition and growth of planning, analysis, data-gathering, research, and policy-formulation processes in the health sector. This stage, in the case of the Korean Government, will apply in particular to the following agencies and their subsidiary agencies:

- Economic Planning Board
- Ministry of Health and Social Affairs
- Ministry of Home Affairs
- Korean Development Institute

Among possible activities during this phase, the Korean Development Institute could be tasked to undertake a study looking to a definition of

the health objectives that Korea should be targetting towards, and sharpening definition of the processes in the Korean context (Figures A and B) through which planning in the health sector can be translated into policies and programs that support ROKG health objectives.

Another possible activity during this phase would be the tasking of an institution or two or individuals of competence to study the information system needs of the health planning process as these relate to the Ministry of Home Affairs operation of the health services throughout the country.

A third possible activity during this phase would be a study by competent Korean institutions or individuals of the economic analysis and judgmental criteria used by the Economic Planning Board when assessing the content and priorities attached to proposed alternative courses of action in the social and economic sectors.

A fourth possible activity, which might stretch through all phases, would be the tasking of several research studies aimed at obtaining various kinds of "base-line" data concerning the current situation in the health sector in rural areas throughout the country.

2. Planning and Research Process

This involves the implementation of the flows and parts as outlined in Figures A, B, and C above. Included in this phase are:

- Identification of the needed research agenda;
- Content and organization of the needed information system;
- Selection of the best prospects for innovative testing of alternative health delivery and financing options.

3. Implementation and Evaluation

This concerns operationalization of the research agenda, 9/ including the testing of the innovative options for health delivery and financing. Included in this must be the implementation of the research contract approach as illustrated in Figure E, Research Process Path, above.

The evaluative aspects of this stage refers to the evaluation of the effectiveness of the whole system and not the specific research activities. In both the total system as well as the specific activities, continuous feedback will be expected in order to enable periodic evaluation and "course adjustments" particularly at the time of the first twelve-month joint review of the project.

4. Training

During all phases of the project, there will be constant emphasis upon defining the skills and systems for which training is required, identifying the best qualified training institutions, setting the optimum training norms and schedules, establishing the criteria for selecting those best qualified for training, recruiting the trainees and placing them in training settings, monitoring their performance, and situating them - upon completion of training - in the correct positions where they can be most effective.

In this connection, it may be necessary to commission one or several studies aimed at assessing the correct training objectives configurations, schedules, placements, and assignments.

9/ Because of earlier analysis of certain promising pilot schemes, design of some field tests may be ready before FY 1976.

5. Coordination

As in the case of training, this will be an element that will run concurrently through all phases; but it's greatest priority emphasis will come in the first months of the project. It is at that time that the systems, organization, and process of coordination must be established within the Korean government and between the Korean government and USAID.

During the first three months of the project, various configurations may be examined prior to adoption of one for test. One representative example might be the formation of two devices aimed at promoting communication and coordination. These would be:

- A National Health Planning Council comprised of (possibly):
  - Representatives from ministries involved
  - Korean Medical Association Representative
  - Representatives from Medical Schools and from the School of Public Health, SNU
  - Legislative representatives
  - Representatives from provinces
  - Korean Nursing Association President
- A Inter-Ministerial Health Planning Committee comprised of (possibly):
  - Key officials of the Economic Planning Board, the Ministry of Health and Social Affairs, and the Ministry of Home Affairs
  - A representative of the National Health Planning Council.

Under such a configuration the relevant technical assistance, research, training, etc., would be assigned, and guided through the Inter-Ministerial Health Planning Committee subject to policy guidance from the National Health Policy Planning Council.

Narrative Statement

The nature of the changes in planning systems and processes envisaged in this project make it essential that policy formulation based upon careful reference to both economic and social analysis be a constant goal in all that is done.

To further this, the correct linkages and organizational configurations for each portion of the planning process must be built in from the beginning. Hence the stress upon an initial three-month interval devoted to identifying and establishing these locations and responsibilities. The twelve-month joint review is also expected to expose errors in original assignments of responsibility and organizational designs and signal necessary adjustments.

In this connection, it would appear reasonable to assume that the precise assignments and working centers for AID-provided technical assistance will be determined during the first three months and periodically reassessed during the ensuing months of operation.

Another early step concerns definition of the desired country health objectives and an analysis of their determinants. In this connection, it is essential that institutions like the Korean Development Institute (KDI) be encouraged to undertake the task of bringing together a team of health planners, economists, and health professionals to focus on such matters. This might be done in conjunction, also, with organizations like the National Institute of Health (NIH) either together or separately.

Such activities, when undertaken, will enable the health professionals, economists, and planners to proceed with defining the various projects

and programs that may have a direct bearing on the determinants of the health objectives. Korea possesses a very rich institutional environment which lends itself to such messages.

Other ROKG entities have successfully utilized the advisory services of contract research institutions such as the Korean Education Development Institute (KEDI), the Korean Institute for Research in the Behaviorial Sciences (KIRBS), and the Korean Institute of Science and Technology (KIST) plus the many university-based institutes and research programs.

These circumstances also favor the development of contracts aimed at testing the operationality of a health sector planning process and/or some component or components of a health delivery system. Similarly, study of the more readily identifiable health indicators such as intermediate efficiency indicators may also be undertaken through such means.

Assuming that success of the above approaches, and others not specified here, is attained then the USAID/Korea technical assistance inputs can most effectively advise on the necessary planning systems and training required to establish a viable national health sector planning capability.

Working with the assistance of the Ministry of Home Affairs, this can be done not only at the national level, but also at Province and Gun levels where, at present, the planning processess are most redimentary.[10/]

10/ Some observations on the status of health planning in the Province and Gun levels, based on a limited field visit in two provinces are attached as Appendix D.

Table 1: Manpower & Participant Training Requirements, ROKG/Health Sector Planning FY 1975, 1976

	FY Quarter FY 1975 1 2 3 4	FY 1976 1 2 3 4	Total Man-Month
I. U.S. PERSONNEL			
A. Long-Term Technical Advisors			
Health Economist	x x x x	x x x x	24
Health/Admin Systems	x x x x	x x x x	24
		Sub-total	48
B. Direct-Hire USAID/K			
Health Specialist	x x x x	x x x x	24
		Sub-total	24
C. Short-Term Consultants - Specialists (Examples)			
Information	x x	x	8
Evaluation	x	x x x	10
Manpower	x x	x x	4
Experimental Design	x x	x x	4
Policy Analyst	x	x x x	5
Public Health Adm.	x x	x x	6
Hosp. Manag't.	x x	x x	8
Health Education	x x	x x x	6
Cost Accountant	x x	x x	4
Actuary	x x	x x	7
		Sub-total	60
II. ROKG PERSONNEL			
A. Organizational Planning			
Planning Director	x x x x	x x x x	24
Research Mgt. Director	x x x x	x x x x	24
Senior Health Economist	x x	x x x x	18
Health Systems Analyst	x x x x	x x x x	24
Support Staff (6)	x x x x	x x x x	144
		Sub-total	234
B. Planning & Research Process			
Health Planning Analyst	x x x x	x x x x	24
Senior Research Assistant (Rename to comply with ROKG Adm.)	x x x x	x x x x	24
Health Planning Analyst	x x x x	x x x x	24
Senior Research Analyst	x x x x	x x x x	24
Support Staff	x x x x	x x x x	96
		Sub-total	192
III. PARTICIPANT TRAINEES			
Degree Participants	x x x x	x x x x	96
Short-term Observation (On-the-job-training)	x x x x	x x x x	32
		Sub-total	128

Table 2: Budgetary Resource Requirements,
ROKG/Health Sector Planning
FY 1975 - FY 1976

(In 1000 U.S. Dollars)

	FY 1975	FY 1976
Proposed U.S. Contribution		
I. Dollar Costs		
A. Personnel (Contract)		
1 DH Health Planning Specialist (Funded from operating costs)		
1 Health Economist	45	45
1 Health Administration	45	45
30 man months consultant (per year)	125	125
B. Participants (Illustrative)		
4 Long-term academic participants (MPH - Health Planning) ($9,000)	18	18
8 Short-term (1-2 mos.) Observation (U.S. & Third Country) ($25,000)	12	12
C. Commodities		
Equipment for Support of Contract Team	20	--
D. Research Trust Fund	100	100
Total	365	345
Proposed ROKG Contribution		
II. Won Costs ($ Equivalent)		
A. Direct Project Support @ $3,000 per consultant and $10,000 internal travel; secretarial, etc.	16	16
B. Research Trust Fund FY 75 (KDI Study-Field tests Health insurance, etc.)	150	150
C. ROKG Planning Staff	75	85
Total	241	251

Summary	Objectively Varifiable Indicators	Important Assumptions
Goal Enhanced public welfare in rural areas through expanded health, sanitation, and social security programs and facilities based on economically sound and site-tested planning systems.	A. 2. Measures of Goal Achievement (1) Increase in rural medical facilities from present 10% to 34% by 1976. (2) By 1975 all public health sub-centers will be manned by qualified doctors. (3) T.B. prevalence rate will drop from 3.4% to 2% by 1976. (4) Parasitic infected population to drop from 60% in 1972 to 50% by 1976. (5) Percentage of fertile-age group population practicing family planning will increase from 25% in 1972 to 40% by 1976. (6) Potable water supply to demand ratio will increase from 35.5% in 1970 to 51.4% by 1976.	A. 3. As Related to Goal (1) Appropriate financial resources will be available. (2) ROKG priorities for work in social services and health will be seriously adhered to. (3) Collaborative implementing policies and programs will be effectively connected to planning and policy-formulation systems so as to insure the needed deployment of manpower and physical facilities both at the national and provincial levels. (4) Efficiency of both capital & human resources in the curative & preventive health sector can be improved through changes in the policy instruments such as licensing, salaries, definition of para-medic responsibilities,
B. 1. Purpose Establish a health sector planning capability supportive of health strategies and systems formulations based on systematic analysis, research, data assessment, and design of appropriate delivery services.	B. 2. End of Project Status (1) Economic Planning Board, the Ministry of Health and Social Affairs, and the Ministry of Home Affairs staffed and linked together in discharging discrete functions related to the health planning process. (2) Health sector management information system installed and monitoring policy and input/output performance from Gun upwards through all levels	B. 3. As Related to Purpose (1) Policy-makers willing to test & accept new institutional configurations and responsibilities for the operation of health planning systems. (2) New health sector planning processes and systems can be designed that are appropriate to

Summary	Objectively Varifiable Indicators	Important Assumptions
B. 1. Purpose (Cont'd)	B. 2. End of Project Status (Cont'd) (3) National Health Planning Council and Inter-Ministerial Health Planning Committee or equivalents thereof organized, staffed, & functioning to insure thorough development & test of health planning systems, processes, & criteria. (4) Developed set of health sector objectives & identified determinants as well as defined conditions of "health status" sought. (5) Analytical decision-making techniques employed in providing the types of plans acceptable to health, economic, & political planners/decision-makers. (6) A network of research/planning competence established through contractual arrangements with public, semi-public, & private research organizations. (7) Mid-term in the development of a cadre of well qualified personnel to meet the manpower requirements for planning and research in the health sector. (8) Operation of at least two & perhaps four major tests aimed at examining cost-effectiveness, public/private sector cooperation, & other aspects of rural preventive & curative health systems on a planned & monitored basis.	B. 3. As Related to Purpose (Cont'd.) (3) The ROKG will insure the utilization of planning output by strengthening the implementation capabilities of both public & private sector health delivery systems and securing full coordination between government agencies concerned with health-related issues & the private sector. (4) That technical assistance can, in fact, contribute to: -Helping identify appropriate organizational & functional configurations & processes for effective health sector planning. -Helping the ROKG identify & analyze the systems & expertise supportive of effective collaboration in health planning and research both within the public sector & with the private sector. -Helping in on-the-job training in appropriate research methodologies, research management, systems design, data-gathering, & analysis related to effective health sector planning. (5) That appropriate ROKG professional manpower are trainable & will be available for training on schedule. (6) That the suggested approach, or some variant, outlined in Section VI, Course of Action, of the PROP will be implemente within the time frame of the project.

Summary C. 1. Outputs	Objectively Varifiable Indicators C. 2. Output Indicators-Magnitudes & Dates		Important Assumptions C. 3. As Related to Outputs
(1) Senior Health Planning Economists trained & employed in EPB and/or MHSA.	2	End of FY 76	(1) The ROKG will assign quality professional staff to health planning & research activities with adequate arrangements & budgets to carry out the specified tasks.
(2) Health Planning & Research Analysts trained & employed within or among the EPB, MHSA, and KDI.	5	Beginning of FY 76	
(3) Planning & Research Directors trained & employed in EPB and/or MHSA.	2	End of FY 75	(2) That the ROKG/EPB/MHSA/MHA & othe related collaborative ministries/ entities will be actively involved from the outset & work closely wit AID-provided technical assistance personnel.
(4) Data-gathering system appropriate to health planning needs designed & under test.	-In 2 provinces -In 4 field test sites	End of FY 76 End of FY 75	
(5) Research and test agenda delineated.	-Base-line studies -Field test innovative modalities of 3 to 4 types -Studies 1 Attitudinal 1 Facilities efficiency 1 Manpower/ functional 1 Costing/effectiveness	Mid-FY 75 End of FY 75 Mid-FY 75 End - FY 75 End - FY 75 Mid FY 75	(3) That within the first three month initial siting of health planning & related functions will be effectively worked out by the ROKG in collaboration with USAID.
(6) Research & test agenda activated & completed.	-See numbers in (5) above	All completed by end FY 76	(4) Contractual arrangements will be acceptable & implemented by the ROKG & appropriate contractors.
(7) Changes effected in planning system as outlined in Figures A & B of PROP.	-National health status defined -Quality health services defined	End FY 75 End FY 76	(5) The products of field operations research will yield results that can and are translated into policy & program operations. (6) That the private sector can be appropriately & effectively engaged. (7) That both preventive & curative low-cost rural health delivery system remain of priority interest.

D. 1. Inputs

I. U.S. Personnel - Man months

1 Health economist	24 mm
1 Health Adm/Systems Specialist	24 mm
1 DH Planning Sp.	24 mm
10 Short-term specialists	
1 Information	8 mm
1 Evaluation	10 mm
1 Manpower	4 mm
1 Experimental design	4 mm
1 Policy Analyst	5 mm
1 Pub.Health Adm.	6 mm
1 Hosp.Mgt.	8 mm
1 Health Ed.	6 mm
1 Cost Accountant	4 mm
1 Actuary	7 mm
Total:	60 mm

II. ROKG Personnel:
8 Health Economists, Research and Planning Analysts
Support Staff
Total Man-Months: 192

III. Participant Trainees:

Degree participants	96 mm
Short-term observation	32 mm
Total	128 mm

D. 2. Budget/Schedule

Proposed U.S. Contribution (1000 $)

I. Dollar Costs:	FY 75	FY 76
A. Personnel (Contract)		
1 DH Health Plan. (funded from operating costs)		
1 Health Econ	45	45
1 Health Adm.	45	45
60 Man-mos.Consult.	125	125
B. Participants		
4 Long-term	18	18
8 Short-term	12	12
C. Commidities: Equipment for support of contract team	20	--
D. Research Trust Fund	100	100
Total	365	345

Proposed ROKG Contribution

II. Won Costs ($ Equivalent)		
A. Direct project support	16	16
B. Research Trust Fund	150	150
C. ROKG Planning Staff	75	85
Total	241	251

D. 3. Assumptions Related to Inputs

(1) AID can obtain the needed direct hire & contract personnel.

(2) AID & and ROKG will obtain the necessary financial commitments.

(3) AID will develop a contract with a competent research organization.

(4) The first 3-month interval fol- developing the project & subsequent 12-month review will produce results that will be effectively responded tc by the programming & delivery of inputs on the part of both the ROKG & A

(5) That the ROKG will produce the be personnel available to staff the heal planning processes & systems; & to ma available, at the agreed upon trainin schedule, the professional to be sent for training.

(6) AID inputs in support of operational research will be flexible, adequate, & appropriate & the sam will be true for ROKG inputs in this area.

Appendix A

Testing of Alternative Health Delivery and Financing Modalities

(Report of Second Group of TDY II Team)

Appendix A - Family Health Care Report - Not attached to PROP.

Report Available:

AID/W: ASIA/TECH/PSD
USAID/Korea

Appendix B

Suggested Job Definitions

and Requirements

Appendix B

Suggested Job Definitions and Requirements

The specific focus of this Appendix B relates to the contract personnel that may be involved in the contract technical assistance component.

It also briefly suggests the nature of the participant training that may be extended to the Korean Senior Staff and/or supporting institutions such as EPB and KDI.

U.S. Technical Advisors (Contractual)

Concern with the technical qualifications of the individuals should not be the sole determinant in the final selection of the advisors. The ability to perceive the multi-faceted aspects of health delivery and planning techniques are very important. Equally important are the abilities to "manage" "blend" and/or "catalyze" the talent that is currently/potentially available within Korea. This

ability should extend to the knowledge of needed talent and information outside Korea that may be tapped for the work order consultancy contract orientation.

Pursuant to the structural and functional components of the health planning process advanced in this PROP, the technical advisors must be able to assist and guide in the:

1. Identification of the problems and/or bottlenecks in the planning process.

2. Translation of the problem(s) into researchable questions with specific reference to the context within which such questions arise and must be implemented.

3. Delineation of the scope of work that will be essential for the development of the in-house or contract request for proposal.

4. Evaluation of alternative cost-effective methodologies and proposals, subject to the decision making time and financial constraints, i.e. how

much is the answer worth to the decision maker both in terms of timeliness of the needed response and the cost of getting the answers.

5. Development of viable and feasible working relationships between the Korean planning staff and the supporting governments and/or private agencies and institutes. Here emphasis is placed on the ability of the advisors to help such staff identify and work with supporting institutional arrangements.

Two resident advisors were identified for this PROP: one an economist with good working experience in the analysis and planning of the social services sector, preferably health; and the second a health administration specialist who has had solid practical experience in exploring and analyzing the various aspects of the health care delivery system. In both cases "pontifical professorial" types are not sought. This requirement by no means underestimates the need for solid analytical expertise but places more

ROKG Personnel

The main thrust of the search for the appropriate ROKG Planning Senior Staff is ROKG's responsibility. However AID/K may be involved in helping identify the required professional characteristics of the Senior Staff. Here only a direction toward the attainment of this goal is advanced.

The recommended direction has as its starting point the knowledge that health planners capable of effectively implementing the various components of the tasks identified in this PROP are not on board and running. Hence a "retreading" philosophy may be appropriate in this situation. The necessity to insure high and genuine commitment to the health planning effort must be safeguarded during the selection phase of the needed personnel.

The "retreading" approach has as its starting point the basic assumption that basic professional competence in one field can and is transferable to a "new" field. With proper working exposure to the

"new" field, i.e. health planning, the needed competence will emerge. Hence the burden of finding the right combination of ROKG professionals shifts to the need for identification of a training observation/"on the job" exposure that will facilitate the mid-career transitioning from the given state to the desired new state of "a health planner-analyst."

Accepting the above rationale, AID/K and AID/W must identify the places and people that are currently involved in one or more of the many aspects of health planning in the U.S. or any third country. The AID/K and AID/W person(s) involved in designing this aspect of the training programs must himself(herself) be fully knowledgeable about training arrangements and opportunities within research or governmental agencies in Europe, the U.S. and elsewhere. Once such a working knowledge of desirable places is acquired then the selected short-term high level Korean planners will be advised to travel and participate on ongoing analysis/planning processes in the selected locales.

Appendix C

Selected Statistical Data

Appendix C Table: Budgetary Allocation by Major Activity, ROKG/MHSA
Table 1 1971-1974 (000 Won)

Category Activity	1971	1972	1973	1974
A. General Account				
Administrative	107,335	122,423	121,995	210,613
Public Health	69,782	76,149	86,391	312,748
Acute Communicable Disease	93,849	126,638	119,175	1/
Environmental Sanitation	255,963	261,645	235,975	259,693
Medical Affairs	430,094	532,443	585,660	866,003
Pharmaceutical Affairs	125,952	145,117	126,526	132,108
TB Control	132,050	186,168	243,291	2/
Leprosy Control	358,650	447,619	570,041	2/
Mental Health	102,404	138,422	182,628	1/
NIH	365,032	437,754	430,632	450,742
Quarantine Office	62,331	91,798	113,813	
Social Affairs	299,192	306,391	424,420	102,9[illegible]
Womens Welfare	107,572	141,967	237,355	714,25[illegible]
Relief Services	2,080,520	2,137,351	2,104,336	2,276,554
Emigration Service	52,943	58,334	32,747	1/
MCH				16,07[illegible]
Communicable disease				934,904
B. Special Account				
Public Health	205,147	240,655	13,821	1/
Environmental Sanitation	200,000	280,000	500,000	913,410
Medical Affairs	817,456	722,211	753,099	462,174
TB Control	522,767	632,342	684,477	1/
Leprosy Control	55,523	66,042	75,421	1/
Social Affairs	2,772,610	2,661,478	800,652	1,377,[illegible]3
Family Planning	760,435	361,092	765,742	829,011
National Welfare (Special Account)				25,187,252
Total MHSA	10,142,899	10,161,512	9,208,497	35,965,182
MHSA as Percent of Total ROKG Budget	0.9	0.8	0.8	1.1(est.)

1/ Changed budgetary categories, hence absorbed into other line items.
2/ Includes TB, Leprosy and Pharmaceutical Affairs.
3/ MCH and Family Planning.

Source: ROKG/MHSA, Major Policies and Programmes of MHSA, 1972; USAID/W, Briefing Document on South Korea, The Health Sector, 1972 plus MHSA Draft Long Term Health Planning, 1974.

Appendix C Table 2: Foreign Assistance to ROKG/Health Sector, 1971

(Unit $1,000)

Organization	Total	Experts	Fellowship	Supplies & Equipment	Cash
U.N. Development Programme (UNDP)	63.0	60.3	3.0		
World Health Org. (WHO)	352.4	287.0	38.3	22.1	
U.N. Children's Fund (UNICEF)	250.2		2.0	108.4	139.8
U.N. Fund for Population Activities (UNFPA)	24.0				24.0
Economic Commission for Asia and the Far East (ECAFE)	2.1		2.1		
Colombo Plan	75.0		75.0		
Scandinavian Mission	215.9		26.9	189.0	
United States Agency for International Development (USAID-K) [1/]	6,050.6	190.0	105.6	5,755.0	
Swedish International Development Agency (SIDA)	661.0			367.0	294.0
Overseas Technical Cooperation Agency Japan (OTCA)	130.5	10.5		120.0	
East West Center (EWC)	25.0		25.0		
International Planned Parenthood Federation (IPPF)	376.9		0.9		376.0

Appendix C Table 2: Continued

Organization	Total	Experts	Fellow-ship	Supplies & Equip-ment	Cash
Population Council of America (PC)	451.0		3.0		448.0
Foreign Voluntary Agencies	26,675.9		12.1	6,564.8	20,939.0
Others			39.7		39.7
Total	35,391.2	1,547.5	331.6	12,221.3	21,289.8

Total USAID Assistance in health related programs to date are estimated at over 20 million dollars. The FP related FY 68-73 programs totalled $12,164,900 while health programs during FY 56-67 totalled 8,076,600 (Source: USAID/K unpublished typed report).

Source: ROKG/MHSA, Major Policies & Programmes of MHSA, 1972 p.89

Appendix C Table 3: Changes in Mortality Indicators, ROKG, Selected Years

Indicator		Year 1960	1970	1973
A. Crude Death Rate (per 1000 Population)		13	8.5	7.5-8.0[3/]
B. Sex/Selected Age-Specific D.R. (per 1000 pop)				
Male	Under 1	118.0[1/]	55.2[2/]	52.7[3/]
	1- 4	11.6[1/]	6.0[2/]	3.6[3/]
	5- 9	2.2[1/]	3.8[2/]	1.5[3/]
	30-34	6.8[1/]	3.3[2/]	2.0[3/]
	55-59	29.9[1/]	31.6[2/]	19.5[3/]
	65-69	60.1[1/]	50.2[2/]	41.2[3/]
Female	Under 1	97.8[1/]	53.9[2/]	45.7[3/]
	1- 4	10.2[1/]	5.9[2/]	3.2[3/]
	5- 9	2.7[1/]	3.8[2/]	1.4[3/]
	30-34	6.4[1/]	3.1[2/]	1.6[3/]
	55-59	23.2[1/]	14.7[2/]	14.3[3/]
	65-69	40.5[1/]	30.5[2/]	28.9[3/]
Selected Disease Specific Death Rates[4/] (per 100,000 pop.)				
Cholera		-	5.8	- (1972)
Dysentery		4.3	2.8	- (1972)
Typhoid Fever		4.5	0.9	- (1972)
Paratyphoid Fever		1.3	-	- (1972)
Small Pox		-	-	- (1972)
Meiningococoal Meningitis		22.7	25.0	- (1972)
Japanese Encephalitis		36.0	7.4	1.3 (1972)
T.B.[5/]		2,254(1964)	6,688	10,397 (1972)

Sources: (1) ROKG/MHSA, Yearbook of Public Health and Social Statistics, 1972.
(2) East-West Center, The Demographic Situation in the Republic of Korea, Hawaii, 1973.

1/ For the period 1955-60.
2/ For 1966.
3/ For 1971 which are derived from 1971 Special Demographic Survey Data.
4/ Based on Number of Deaths as 0 percent of reported cases.
5/ Total reported deaths.

Appendix C Table 4: Selected Communicable Disease Pattern; Number of Cases and Morbidity Rates, Selected Years 1950-1972, ROK

Selected Disease and Indicator	Year					
	1950	1955	1960	1965	1970	1972
Cholera						
Cases	-	-	-	-	206	-
Morbidity Rate[1/]	-	-	-	-	0.7	-
Dysentery						
Cases	322	319	47	355	927	215
Morbidity Rate[1/]	-	1.5	0.2	1.2	3.0	0.7
Typhoid Fever						
Cases	8,810	353	2,798	3,760	4,211	2,030
Morbidity Rate[1/]	-	1.6	11.2	13.1	14.5	6.2
Paratyphoid Fever						
Cases	140	38	77	22	42	9
Morbidity Rate[1/]	-	0.2	0.3	0.1	0.1	0.0
Small Pox						
Cases	2,845	2	3	-	-	-
Morbidity Rate[1/]	-	0	0	-	-	-
Diphtheria						
Cases	1,255	339	828	1,079	567	556
Morbidity Rate[1/]	-	1.6	3.3	3.8	1.9	1.7
Meningococoal Menengitis						
Cases	155	23	22	24	17	-
Morbidity Rate[1/]	-	0.1	0.1	0.1	0.1	-
Japanese Encephelitis						
Cases	98	2,506	1,248	752	27	[illegible]
Morbidity Rate[1/]	-	9.4	5.0	2.6	0.1	[illegible]
Tuberculosis (Registered patients as of end of year)						
Total	N.A.	N.A.	N.A.	71,152	171,464	149,650
Infectious	N.A.	N.A.	N.A.	N.A	80,438	91,026
Non Infectious	N.A.	N.A.	N.A.	N.A.	81,321	68,324

Source: ROKG/MHSA, Yearbook of Public Health and Social Statistics, 1972

1/ Morbidity rate in per 100,000 Population.

Appendix C Table 5: Public Sector Medical Facilities' Distribution, May 1974

Province/Special City	National Hosp No.	Beds	City & Prov. Hospital No.	Beds	Health Center	Health Sub-Center
Kyonggi Province			7	591	26	1
Kangwon Province			6	314	19	90
Chungpuk Province			2	178	12	96
Chungnam Province	1(T.B.)	375	5	254	17	165
Chonpuk Province			4	198	15	149
Chonnam Province	1(Leprosy)	300	4	283	26	212
Kyongpuk Province			6	347	33	230
Kyongnam Province	1(T.B.)	500	2	173	26	211
Cheju Province			2	92	4	11
Seoul Special City	1(General) 1(Mental)	569 500	7	1,427	9	-
Pusan Special City	1(Veteran)	200	1	84	6	-
Total	6	2,444	46	3,941	193	1,342

Source: ROKG/MHSA/Medical Affairs Bureau.

Appendix C Table 6: Health Manpower Availability[1/] and Distribution by Functional Classification and Province, 1972

Province/Special City	Medical Doctors (Licenced)	Dentists (Licenced)	Pharmacists (Registered)	Nurses (Licenced)
Kyonggi Province	1,246	268	380	1,699
Kangwon Province	368	67	81	1,176
Chungpuk Province	464	93	37	1,140
Chungnam Province	882	232	105	1,690
Chonpuk Province	817	80	115	1,921
Chonnam Province	1,753	89	240	2,030
Kyongpuk Province	2,312	239	586	2,699
Kyongnam Province	1,719	245	91	1,956
Cheju Province	145	15	21	145
Seoul Special City	5,762	1,035	3,372	4,015
Pusan Special City	842	89	539	543
Total	16,310	2,452	5,634	19,089

1/ Availability refers to actual numbers now employed in the various health related fields as per ROKG/MHSA classification.

Source: 1972 Yearbook of Public Health and Social Statistics, MHSA.

Appendix D

Province and Gun Health Planning:

Some Observations

Appendix D

Health Planning at the Province and Gun Levels*

The health planning process at the Province and Gun levels mirror the process at the central level. However, additional compounding problems are met because of the administrative arrangements between the health programs at the provincial and Gun levels and the directives and regulations that are centralized in Seoul at the MHSA. National health programs, though funded through a matching type of arrangement (e.g. 70 percent national funds with the remaining 30 percent raised by the province) are administratively controlled by the province while technically "guided" by the appropriate bureau of the MHSA. Being under the Ministry of Home Affairs, the provincial administrative machinery requires the Director of Health and Social Affairs to report directly to the Governor who is appointed by the President through the Ministry of Home Affairs. The Director for Health and Social Affairs, in most instances a civil servant who may come up through the Gun to

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*These observations are based on a limited exposure to field situations in two provinces and must be treated as such.

Province structure, places all of the health related responsibilities within the administrative jurisdiction of the Public Health Chief, who is also civil servant administrator. The chief in turn runs his sub-sections, i.e. health, sanitation, medical and pharmaceutical (curative aspects), and family planning, consistent with the directives sent from Seoul. A principal constraint appears to be the budget, which is appropriated by the province upon recommendations of the provincial "planning coordinator" (who seems more a budgetary officer than a planner).

At the Gun level, the health director is supposed to be the Country's principal public health officer. However, he has jurisdictional, and at times, little communication with the provincial officials. As in the case of the Province health chief the Gun health director reports administratively to the Gun Chief and receives technical supervision and advice from the MHSA <u>through</u> the provincial level.

The objective orientation of planning is almost totally lacking at the Gun and Province levels.

Budgetary line item projections are the main planning tools used. Stress on physical construction, as one of the key visible output of the health budget is obvious. Commanding a low priority health "plans" and their corresponding budgets are usually very drastically reduced at budget appropriation time.*

The situation of the provincial hospital presents a particular dilemma for the local planner. Official salaries are insufficient to attract senior capable staff and allowable hospital fees are not sufficient to allow these institutions to become self-supporting. Hence the local health planners' time is constantly engaged in fashioning a range of jerry built arrangements that will enable the hospitals to

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*The USAID/Health Sector Briefing Document on South Korea, 1972, stated this 'state of affairs' well when it reported, "Planning is done piece-meal in response to the political and financial power wielding by the various government agencies. . . . The absence of a comprehensive approach to health planning results in fragmentation and duplication of services and a consequent waste of precious human and financial resources."

continue functioning absorb**ing** both his planning energies and any surplus health budget.

The efficiency of resource utilization at the local level and the explanation of options needs to occupy a significant position of the planning unit's time and resources.